was introduced and inflated with air. Its pressure did not cause pain, and within the twenty-four hours following, the uterus returned to its normal position. As a rule, in using the bag in this manner it should not be allowed to remain longer than eight hours.

Cesarean Section for Threatened Rupture of the Uterus.—POTOCKI (*Annales de Gynecologie*, May, 1906) reports the case of a patient, a multipara at term, who had been in labor twelve hours without the engagement of the head. Mother and child were in good condition. The pelvis was symmetrically contracted, the anteroposterior diameter measuring 9.8 cm. The type of pelvis was rachitic. When dilatation was complete the membranes were ruptured, amniotic liquid was slightly discolored. The anterior parietal bone presented, but the head still remained immovable. Engagement failed, although means were taken to relieve the patient's suffering. Her pains, however, became so severe as to demand prompt relief. The distension of the lower uterine segment was found to be excessive and uterine rupture was threatened; it was accordingly determined to deliver the child by Cesarean section. On opening the abdomen and the uterus the tissues were engorged and infiltrated with serum, giving evidence of severe birth pressure. A well-developed male child was delivered; the uterus packed with sterile gauze, which was carried through the cervix into the vagina, and the womb was closed by three rows of catgut stitches. Mother and child made good recoveries. The child's head was above the average in size and very well ossified.

Gonorrhœa in the Puerperal Period.—MAYER (*Monatschr. f. Geb. u. Gyn.*, 1906, Band xxiii, Heft 6) reviews the literature of this subject, and concludes that puerperal gonorrhœa may be a dangerous disorder. It can cause high fever and severe general infection with chills. The general picture may be that of systemic septic infection of severe grade. We cannot definitely distinguish how much of this condition is caused by toxins and not by bacteria. In severe cases with high fever we must suppose that mixed infection with streptococci and staphylococci is present in addition to gonorrhœa. Great variations in temperature, alternating between high fever and periods free from fever, are more characteristic of gonorrhœal infection than of sepsis. The statement sometimes made that fever developing late in the puerperal period is characteristic of gonorrhœa cannot be maintained. As regards the effect upon the children, in six children born of a gonorrhœal mother, four would be feeble or deficient at birth, while the other two would have less than usual power of resistance.

Gangrene of the Puerperal Uterus.—SCHMIDLECHNER (*Archiv. f. Gyn.*, 1906, Band lxxviii, Heft 3) reports the case of a patient who had had four normal labors, and who, during the fifth pregnancy, had considerable hemorrhage followed by an offensive discharge. The patient was thought to have had an abortion and was brought to the hospital. On examination a mass of decomposed tissue was found in the cervix. On further examination the uterus was as large as a fist, somewhat sensitive and anteflexed, and its wall very thin. Great care was taken to avoid rupturing the uterus, and a portion of the mass in the cervix was removed for examination. It was found to consist of necrotic uterine tissue, fibrin, disorganized and unrecognizable

cells, blood pigment, and pus cells. The patient grew worse, although on examining the blood no pathological organisms of an infectious character could be found. She was thought to have chorio-epithelioma or gangrene of the uterus. Under anesthesia the uterus was removed through the vagina; the right ovary was also removed, and the stumps of the broad ligaments brought into the vaginal wound, and packing of iodoform gauze inserted. On examining the uterus its muscle was found to be a dirty grayish brown and highly disintegrated. In several places the uterine wall was almost perforated. On microscopic examination the tissues were found in a condition of cellular necrosis. The patient made a speedy and an uninterrupted recovery.

GYNECOLOGY.

UNDER THE CHARGE OF

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Dermoid Cysts of the Ovary.—SCHOTTLAENDER (*Archiv. f. Gynäkologie* 1906, Band lxxviii, Heft 1) found in the walls of these cysts numerous cavities lined, and often filled, with epitheloid and giant cells, which represent dilated lymphvessels due to the irritation caused by the invasion into them of sebaceous material from the skin. This cell proliferation may be so marked as to justify the diagnosis of lymphangioma or endothelioma. The fact that these spaces are lined with lutein membrane does not prove that dermoids are developed from the ovum. According to Schottlaender they are secondary cysts; whether they all develop in this way, or are due to fetal inclusion, is not yet certain.

The Physiology of Uterine Contraction.—KURDINOWSKI (*Archiv. f. Gynäkologie*, 1906, Band lxxviii, Heft 1) from experiments on rabbits finds that cold excites contraction more than heat. Cold water acts more promptly in cases of uterine hemorrhage and a less quantity is required; nor is an intrauterine injection required, since the mere contact of cold with the portio is enough to excite general contractions. Long-continued mechanical irritation, as by rubber bags, leads to atony of the uterine muscle. Weak stimuli are better, such as electricity.

Intestinal Fistulæ following Laparotomy.—OSTERLOH (*Zentralbl. f. Gynäkologie*, 1906, No. 34) reported ten cases of intestinal fistulæ following laparotomy, with eight recoveries. In every instance the fistula healed spontaneously. In the discussion of the paper Leopold reported three cases, two terminating fatally; Peters two cases, in which the fistula closed without operation. The latter thought that in these cases the prime factors in the causation of the fistula was a peculiarly soft condition of the intestinal wall in a given case, especially when it was adjacent to a purulent collection.